



Transcript of the Testimony of **IDD-TAC**  
**Meeting**

**Date:** July 11, 2018

**Case:** IDD-TAC Meeting, Frankfort, KY

Todd & Associates Reporting, Inc.

Phone: 859-223-2322

Fax: 859-223-9992

Email: [office@toddreporing.com](mailto:office@toddreporing.com)

Internet: [www.toddreporing.com](http://www.toddreporing.com)



COMMONWEALTH OF KENTUCKY  
CABINET FOR HEALTH AND FAMILY SERVICES  
DEPARTMENT FOR MEDICAID SERVICES  
"INTELLECTUAL AND DEVELOPMENTAL DISABILITIES  
TECHNICAL ADVISORY MEETING"

PUBLIC HEALTH BUILDING  
275 EAST MAIN STREET  
FRANKFORT, KENTUCKY 40621

JULY 11, 2018

10:00 a.m.

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ATTENDEES

2

Rick Christman, KAPP  
Johnny Callebs, KAPP

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Katie Bentley, CCDD  
Wayne Harvey, KAPP

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Alice Blackwell, DDID  
Lori Gresham, Medicaid

5

Alisha Clark, Medicaid  
Sherri Brothers, Arc of KY

6

LeAnn Magre, WellCare  
David Hanna, PASSPORT

7

Carissa Shell, The Point  
Steve Shannon, KARP

8

Tammy Gannon, The Point  
Camille Collins, P&A

9

Laura Presley, DCBS  
Elizabeth Kries, DDID

10

Darin Brown, DAIL  
Marissa Poole, DAIL

11

C. J. Jones, DMS  
Candace Crawford, DMS

12

Kim Prather, Zoom Group  
Brad Schneider, LifeSkills

13

Brittany Knoth, Path Forward of KY  
Chris Stevenson, Leading Age

14

Stayce Towles, DXC  
Lisa Elstun, KAPP

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Earl Gresham, DMS  
Pam Smith, Medicaid

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Kendra Sears, Medicaid

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1 PROCEEDINGS

2 MR. CHRISTMAN: Let's just go  
3 around and introduce ourselves. I am Rick  
4 Christman, and I am the Co-Chair of this group.  
5 I guess I'll chair it for now.

6 MR. CALLEBS: I'm Johnny Callebs,  
7 the Executive Director of KAPP. I'm not on the  
8 Committee. I'm just sitting here.

9 MR. HARVEY: Wayne Harvey. I  
10 represent the for-profit providers with the KAPP  
11 organization.

12 MR. STEVENSON: Chris Stevenson.  
13 I'm President and CEO of Cedar Lake in  
14 Louisville, but I'm representative of Leading Age  
15 of Kentucky, and I serve on the Committee.

16 MS. BENTLEY: Hello. I'm Katie  
17 Bentley. I'm the Public Policy Coordinator for  
18 the Commonwealth Council on Developmental  
19 Disabilities.

20 MS. TOWLES: I'm Stayce Towles  
21 with DXC Technology.

22 MR. CANNON: I'm Candace Crawford.  
23 I'm with Medicaid.

24 MS. CLARK: Alisha Clark,  
25 Medicaid.

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1	MS. SMITH: Pam Smith, Medicaid.
2	MS. JONES: C. J. Jones, Medicaid.
3	MS. GRESHAM: Lori Gresham,
4	Medicaid.
5	MS. SEARS: Kendra Sears,
6	Medicaid.
7	MS. PRESLEY: Laura Presley, DCBS.
8	MS. MAGRE: LeAnn Magre, WellCare.
9	MS. ELSTUN: Lisa Elstun with
10	Dungarvin.
11	MS. SHELL: Carissa Shell, The
12	Point.
13	MS. GANNON: Tammy Gannon, The
14	Point.
15	MS. KRIES: Elizabeth Kries, SCL
16	Waiver Manager.
17	MS. BLACKWELL: Alice Blackwell
18	with DDID.
19	MR. HANNA: David Hanna with
20	Passport.
21	MS. COLLINS: Camille Collins with
22	Protection & Advocacy.
23	MS. POOLE: Marissa Poole, DAIL.
24	MR. BROWN: Darin Brown, DAIL.
25	MS. KNOTH: Brittany Knoth, Path

1 Forward of Kentucky.

2 MR. CHRISTMAN: Sherri, you're  
3 here. This will give us a quorum. Sherri, do  
4 you want to introduce yourself?

5 MS. BROTHERS: Sherri Brothers  
6 with Arc of Kentucky.

7 MR. CHRISTMAN: Would you like to  
8 introduce yourself?

9 MS. PRATHER: Me?

10 MR. CHRISTMAN: Yes.

11 MS. PRATHER: I'm Kim Prather with  
12 Zoom Group. I just ran up the steps. Just give  
13 me a second. Where is a chair I can fall into?  
14 Thanks.

15 MR. CHRISTMAN: Sherri, do you  
16 want me to go ahead?

17 MS. BROTHERS: Sure.

18 MR. CHRISTMAN: First item is  
19 Patient Liability Policy, which -- has everyone  
20 received that or aware of that? And I'm sure  
21 there's going to be some questions about that.  
22 Who's here to talk to that issue?

23 MR. GRESHAM: I am.

24 MR. CHRISTMAN: Okay. Do you have  
25 any questions, Johnny?

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1 MR. CALLEBS: No.

2 MR. CHRISTMAN: Do we have any  
3 questions about that, or concerns?

4 MR. CALLEBS: Let's let Earl give  
5 a quick synopsis of it, and then we'll see  
6 what comes --

7 MR. CHRISTMAN: Yeah, that's a  
8 better idea. Go ahead and give us a quick  
9 description of it.

10 MR. GRESHAM: Okay. We mailed out  
11 a letter. Beginning August 1st, each recipient  
12 that has a patient liability will be required to  
13 pay all other patient liability, unless a  
14 provider wishes to continue their possible  
15 business model of paying it for them.

16 The patient liability is what is  
17 required of that recipient to pay in order to keep  
18 their Medicaid waiver.

19 MR. CHRISTMAN: Why would a  
20 person necessarily have a patient -- what are  
21 some examples of why a person would have a  
22 patient liability?

23 MR. GRESHAM: Is Laura here?

24 MS. PRESLEY: It goes by their  
25 income. It depends on if they're single or

1 married. There is a personal needs eval that we  
2 eval, but anything over that, we allow medical  
3 deductions as well towards the patient liability.  
4 They need to pay for the services.

5 MR. CHRISTMAN: So, for example,  
6 if they might have another source of unearned  
7 income, like SSDI or something like -- is that --

8 MS. PRESLEY: Correct. Like their  
9 social security, if they have a pension, anything  
10 over the personal needs and medical deductions,  
11 we submit a need to pay for patient liability.

12 MR. CHRISTMAN: Let me ask you  
13 this, is there any way --

14 MS. BENTLEY: I'm having a hard  
15 time hearing you.

16 MS. PRESLEY: Sorry. It goes by  
17 their income. Say, if they have social security  
18 income, a pension income, we do allow a certain  
19 amount for personal needs allowance to pay for,  
20 you know, their home, their utilities, such like  
21 that. We also allow certain medical expenses.  
22 We subtract all that, and what is left is what's  
23 considered their patient liability.

24 MR. CHRISTMAN: Would there be  
25 ways that we could look at reducing patient

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1 liability by finding some medical -- by sharing  
2 some of these medical expenses? Do you have an  
3 allowance for that or --

4 MS. PRESLEY: We do.

5 MR. CHRISTMAN: I mean, it's  
6 possible for people to bring down their patient  
7 liability?

8 MS. PRESLEY: Correct.

9 MR. CHRISTMAN: Can you talk about  
10 some of those reasons?

11 MS. PRESLEY: Like if they have  
12 physician expenses, they have their -- if they  
13 have an outstanding bill from a previous waiver,  
14 if they didn't have any medical at that time, we  
15 allow that. If they have prescriptions, cost to  
16 go to the doctor. It depends on what they have  
17 and what they give us. If they don't give us  
18 those expenses, we don't know to give it to them.

19 MR. CHRISTMAN: Is there like a  
20 list of those kind of things on a website?

21 MS. PRESLEY: It is. And it's in  
22 the policy for DCBS.

23 MR. CHRISTMAN: Okay. That we  
24 could share with our memberships? That would  
25 be -- obviously, a good place to start is reduce

1 the liability.

2 MS. PRESLEY: It is. Reduce  
3 allowable expenses to --

4 MR. CHRISTMAN: Right.

5 MR. CALLEBS: Is there a set -- a  
6 fixed amount on the personal needs allowance for  
7 people in waivers? For example, the SCL waiver,  
8 is that a fixed amount for someone --

9 MS. PRESLEY: And it does change  
10 each year, depending on if they receive -- it's  
11 based on their income. It goes by the federal  
12 poverty level. I believe this year it's 741.

13 MR. CALLEBS: 741. So if a person  
14 has income beyond \$741 per month, then that would  
15 be considered patient liability?

16 MS. PRESLEY: Correct.

17 MR. CALLEBS: Okay. For SCL? Or  
18 for all 1915(c) waivers?

19 MS. PRESLEY: Correct.

20 MR. CALLEBS: Thank you.

21 MR. CHRISTMAN: Is earned  
22 income -- non-earned income kind of the same,  
23 just it's all -- like if it's a pension, it's  
24 kind of the same as earned income?

25 MS. PRESLEY: That's an unearned

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1 income. We have earned income where they're  
2 actually earning wages, and then unearned is  
3 anything that they received income for but  
4 they're not actively working.

5 MR. CHRISTMAN: If it's earned  
6 income, is it a higher allowance then?

7 MS. PRESLEY: It's -- what we do  
8 with the earned income is we take off \$65 and we  
9 remove half of what's left.

10 MR. CHRISTMAN: So just like SSI?

11 MS. PRESLEY: Right.

12 MR. CHRISTMAN: Okay.

13 MS. COLLINS: I've been out the  
14 last couple of weeks. So I'm out of the loop on  
15 some of the patient liability. But my  
16 understanding, prior to me going on leave, is  
17 that the State does have the ability to reduce  
18 the liability.

19 With other states, the liability is  
20 less, and we are trying to look at that matter and  
21 talk to the providers about that issue and some  
22 solutions. So I am happy to give you further  
23 information. I can't talk about it right now,  
24 because I don't have that information in front of  
25 me and I've been gone.

1 But it is our understanding  
2 that there can be other reasons --

3 MR. CHRISTMAN: Well, I would  
4 think that's a great solution. If we can  
5 eliminate the patient liability, then we don't  
6 have --

7 MS. COLLINS: Right, we have --

8 MR. CHRISTMAN: -- then we don't  
9 have -- because I understand where the State is  
10 coming from, because they are not collecting it.  
11 But -- I don't know. It's just a conundrum  
12 because getting it from the provider is -- it's  
13 the first provider that submits a bill and gets  
14 hit -- I mean, it's just kind of a crazy -- I  
15 don't know how to make it better.

16 MS. COLLINS: It's just how the  
17 State chose to --

18 MR. CHRISTMAN: Right, yeah.

19 MS. COLLINS: -- place the patient  
20 liability. And other states, they address it  
21 differently based on different -- other  
22 equations.

23 MR. CHRISTMAN: So in other states  
24 the patient liability issue is not an issue?

25 MS. COLLINS: It's not as big an

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1 issue, correct.

2 MR. CHRISTMAN: Okay. Are you  
3 optimistic that we'll be able to --

4 MS. COLLINS: I think I'm  
5 optimistic to get it resolved and to be able to  
6 address it and discuss it. I think we have to --  
7 some discussions with some policy makers. It may  
8 be something that needs to be changed on the  
9 applications. I don't -- again, I need to get  
10 some order about it, but -- I do know that there  
11 are some legislation --

12 MR. CHRISTMAN: Okay. You  
13 mentioned talking to the legislature. This does  
14 require -- does it require a regulation change or  
15 a legislative change?

16 MS. COLLINS: It's my  
17 understanding that I believe it's more of an  
18 application process. But again, Rick, let me get  
19 additional information and I'll contact you  
20 directly about that --

21 MR. CHRISTMAN: All right. Sounds  
22 good.

23 MS. COLLINS: -- that might be  
24 helpful to us.

25 MR. CALLEBS: Can I --

1 MR. CHRISTMAN: Yeah, go ahead.

2 Yeah, sure.

3 MR. CALLEBS: All right. I was  
4 just going to -- and we've already discussed this  
5 somewhat. Earl, Alisha, and Pam, just there's a  
6 concern among providers and, I think, families  
7 that there might be confusion about how the  
8 patient liability gets collected.

9 For example, like if a person has a  
10 \$500 patient liability for the month, and the  
11 first SCL provider or Michelle P provider to bill  
12 that month takes a \$300 cut of that, that leaves  
13 \$200. So then the next provider that bills on the  
14 plan, they take up the remaining \$200. You're  
15 going to have two different providers, and  
16 potentially many more, going to the family to ask  
17 them to pay these patient liability amounts.

18 So there's just concern about how  
19 we educate -- if that can't change, how can we  
20 educate families about that and to get them to  
21 understand what patient liability is and why you  
22 may have to write three or four or five checks in  
23 a month to pay your patient liability to a  
24 different set of providers --

25 MR. CHRISTMAN: So we're not

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1 double billing?

2 MR. CALLEBS: Right. And that  
3 you're not, you know -- so I think there's  
4 potential there for a lot of confusion among  
5 providers and recipients.

6 MS. BROTHERS: I think they're  
7 already confused about all of the different --  
8 what they're already receiving. They're not  
9 understanding what's happening.

10 MR. CALLEBS: Okay. Yeah, it just  
11 puts -- it's a tough spot to be in if you're a  
12 provider and also, you know, having to reach out  
13 to families and bill them when they think that  
14 their services are already covered. And then  
15 they -- training provider bills them, and then  
16 the respite provider bills them, and then the  
17 waiver's provider bills them. So you could  
18 have --

19 MR. CHRISTMAN: It seems like a  
20 lot.

21 MR. CALLEBS: I can see chaos  
22 ensuing if you -- especially in areas of the  
23 state like northern Kentucky and some other areas  
24 where it's the norm to have four or five or six  
25 providers on a plan of care.

1                   So I just wanted to bring that to  
2     the attention of the committee, so that if there's  
3     any way to mitigate that confusion or --

4                   MR. CHRISTMAN: From the  
5     department -- I mean, is that something we could  
6     maybe make a recommendation to the TAC? At least  
7     we get this resolved with the patient liability,  
8     that the -- how have you communicated this to  
9     participants so far?

10                  MR. GRESHAM: We sent them  
11     letters.

12                  MR. CHRISTMAN: Yeah.

13                  MR. GRESHAM: We've also notified  
14     all the providers. Case managers should be  
15     speaking to their -- case managers and support  
16     brokers should be speaking to members to explain  
17     the letter as well as what has occurred.

18                  MR. CHRISTMAN: Do we feel that's  
19     adequate?

20                  MR. CALLEBS: I don't know yet. I  
21     haven't heard from -- what have you all been --

22                  MR. CHRISTMAN: Yes.

23                  MS. ELSTUN: We feel that several  
24     of the families who have received the letter are  
25     confused.

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1 MS. BROTHERS: I do, too. I feel  
2 that way.

3 MS. ELSTUN: They're just like,  
4 what is this? Is this a bill? Who am I going to  
5 have to pay? Who am I paying this to? They're  
6 just kind of confused about the letter itself.

7 So we've been trying to educate  
8 them a little bit more, explain the letter. Also  
9 trying to find everybody that does have a patient  
10 liability, trying to get with their team on  
11 working out a plan of trying to figure out, okay,  
12 day program, when do you typically bill, when are  
13 we billing, we are on a two-week cycle, so is that  
14 going to affect your billing as a case manager  
15 this one time a month or whatever.

16 So trying to basically coordinate  
17 that on an individual basis with everyone.

18 MR. CHRISTMAN: That's really  
19 complicated.

20 MS. COLLINS: It is. It  
21 definitely is unless it's been taken out of your  
22 check. So...

23 MS. ELSTUN: Right. But we're  
24 also -- because there are some of our folks that  
25 have like a -- I have one lady, she gets survivor

1     benefits from her father passing away. So -- and  
2     she has a day program. She has bigger supports  
3     and depending on when they bill -- that's why  
4     we're trying to make sure we're kind of all on  
5     the same page with that.

6                     MR. CHRISTMAN: Well, it strikes  
7     me as kind of really directing the case managers  
8     in a very clear way, that you need to be doing  
9     this, would help a lot, wouldn't it?

10                    MS. ELSTUN: That would be  
11     fantastic, but we're running into a little bit --  
12     and here's part of the issue. A lot of the case  
13     managers, they don't understand patient  
14     liability. And we have some case managers that  
15     say, well, I don't want her financials. You  
16     know, they don't -- they just don't understand  
17     that part of it.

18                    MR. CHRISTMAN: Well, so maybe  
19     making it abundantly -- I mean, you have a list  
20     of all the case managers, I suppose --

21                    MR. GRESHAM: Yes, we do.

22                    MR. CHRISTMAN: -- or case  
23     management agencies. And maybe it's worth  
24     multiple reminders or a webinar training or --  
25     does that make sense?

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1 MR. GRESHAM: Yeah.

2 MS. BROTHERS: That's what I was  
3 going to say, a training. Is there someone that  
4 the families could contact? Is there a number or  
5 name that we could --

6 MR. GRESHAM: It's on the letter.

7 MS. BROTHERS: They're still not  
8 knowing what to do. So is there something that  
9 we could post or something we could put out  
10 there?

11 MR. GRESHAM: I sent out the  
12 member letter to all the providers. I believe  
13 it's also posted on the website, isn't it?

14 MS. CLARK: Yes.

15 MS. COLLINS: I suggest that  
16 Sherri could give equipment to assist to  
17 individual families and individuals for patient  
18 liability for verification and communication from  
19 Medicaid and DCBS.

20 MR. CHRISTMAN: Did you like tell  
21 the case managers it's among their  
22 responsibilities to do this, or when you notified  
23 the case managers, like this is something you  
24 have some responsibility to do or --

25 MR. GRESHAM: I don't know if that

1 direct verbiage was used. I recommended in all  
2 communications, I believe, that the -- this be  
3 discussed at the person centered planning meeting to  
4 make sure that everybody is in the understanding  
5 and that they -- providers are able to work out  
6 billing and all that good stuff.

7 I can't remember if I put anything  
8 that direct in the communication as far as being  
9 case manager and support brokers' responsibility  
10 to ensure the recipient understood.

11 MR. CHRISTMAN: It sounds like  
12 some of the case managers aren't getting the  
13 message. But they are, right? I mean --

14 MR. CALLEBS: In going forward in  
15 the redesign process, I know there was some  
16 mention that the possibility would be for, in the  
17 future in redesign, for Medicaid to collect  
18 patient liability directly from the recipient  
19 rather than deducting it from provider payments  
20 and having the provider collect. Is that  
21 still --

22 MR. GRESHAM: It's something that  
23 we are considering, but no decisions have been  
24 made, nor how we would actually go about doing  
25 it.

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1                   MR. CALLEBS:   Okay.   Just my  
2   opinion, I think that would be the better way to  
3   go just because if you're -- a person owes a  
4   payment or debt to another party, then they can  
5   pay directly to that party rather than pay  
6   that to --

7                   MR. CHRISTMAN:   I thought that's  
8   how it had been.   How was it before this?

9                   MR. GRESHAM:   The providers  
10   collect it, but it's taken out of various  
11   entities throughout each waiver.

12                  MR. CALLEBS:   So they deduct what  
13   was owed from the provider payment and the  
14   provider collects it from the person.

15                  MR. CHRISTMAN:   That's always been  
16   the case?

17                  MR. CALLEBS:   That's my  
18   understanding.

19                  MS. GANNON:   It's the provider who  
20   had the largest bill --

21                  MS. SMITH:   Depending on each  
22   waiver -- each waiver was a little bit different.  
23   And it was, prior to this -- it was way prior to  
24   this -- end of the 90's.   Prior to this, all the  
25   patient liability was collected.

1                   Then there was changes that were  
2     made to assign a primary provider. So depending  
3     on which waiver you were in -- so if you were in  
4     SCL and you were residential or you were in ABI,  
5     you likely had been paying your whole patient  
6     liability this entire time. Whereas, somebody in  
7     HCB might have only been paying a portion of that.

8                   So that's not really equitable  
9     among the population either to expect one, just  
10    because you're in residential, to pay all of the  
11    patient liability but another, because you're not,  
12    to not pay all of the patient liability.

13                  So this is making it the same  
14    across all of the waivers because it really has to  
15    do with eligibility, not which waiver you're in.

16                  MS. KRIES: I just wanted to say  
17    that we have talked to our team at DDID and  
18    beginning tomorrow, I think is our next case  
19    management training, we are going to talk about  
20    this case management training. We've already  
21    talked to our QAs to start providing technical  
22    assistance to case management about ways to look  
23    at this, as far as a team approach.

24                  So we're trying to be proactive and  
25    talk to providers, and also if they have

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1 questions.

2 MR. CHRISTMAN: Okay. Do you  
3 think we have enough to tell our membership  
4 what's going on?

5 MR. CALLEBS: It's changed. I  
6 think the effort, I guess, is just --

7 MR. CHRISTMAN: Sounds like  
8 there's going to be an effort for a long-term  
9 solution and maybe some shorter term solutions  
10 with case managers, right, is how I'm taking it?

11 Is that how you're taking it?

12 MR. HARVEY: I was just going to  
13 add, I think that's a good idea. I think one of  
14 the things, though, that has to be put out there,  
15 especially with case managers, is the fact that  
16 this is not providers collecting money for  
17 providers. This is about the participant's  
18 eligibility and them paying for it, making sure  
19 that they pay that for their eligibility.  
20 Because if they don't pay it, then they're the  
21 ones at risk.

22 So many times people have put  
23 providers in the bad light saying -- or families  
24 have, and other entities that speak about patient  
25 liability and saying, oh, this is another bill the

1 providers are collecting or whatever. And all  
2 we're doing is ensuring their eligibility stays in  
3 place.

4 MS. KRIES: We pretty much are  
5 couching it in that we want to make sure the  
6 people who have the services don't lose their  
7 Medicaid. And that -- so people -- if someone  
8 hasn't paid or a guardian who is paying, they're  
9 doing what they are supposed to do and not  
10 putting off that obligation so somebody doesn't  
11 lose their services.

12 MR. GRESHAM: That's also in the  
13 communication out to members as well, that it's  
14 their responsibility to pay.

15 MR. HARVEY: And I can understand  
16 the confusion that's coming with these letters  
17 and stuff. Because for years it has been, as she  
18 described earlier -- I've forgotten her name --  
19 usually the residential provider is the one  
20 that's stuck collecting, I guess would be best  
21 word to say.

22 And that's a change for some people  
23 because now there's going to be three or four  
24 providers involved in collecting that. So it's  
25 going to be a change because instead of that

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1 family or that individual paying that one entity  
2 and thinking that their eligibility is taken care  
3 of -- because, initially, I can see them thinking,  
4 oh, it's went down, I only owe this one provider  
5 that I've paid for ten years, you know, \$100 just  
6 for example, where it used to be \$250. I'm just  
7 making these numbers up.

8 MS. KRIES: And it's a complicated  
9 conversation for case managers to have, I  
10 understand that, because providers have their own  
11 schedules about when they typically bill this or  
12 for this or for this. And so we try to  
13 individualize that for every person how  
14 complicated that can get, and that kind of thing.

15 So we're definitely going to talk  
16 to case managers about understanding that and how  
17 to work with the team to make sure participants  
18 are protected and providers are billing as they  
19 need to bill.

20 MR. CALLEBS: Can I ask another  
21 question? Can I ask a question about how this  
22 affects eligibility? Would a person ever really  
23 lose their eligibility if they don't pay?  
24 Because, in fact, they are paying their share  
25 because you're automatically deducting it from

1 the provider payment.

2 So Medicaid is getting its patient  
3 liability paid via deducting it from the provider  
4 reimbursement, and then the provider has to  
5 collect. The providers don't determine  
6 eligibility. So patient liability is being paid  
7 and collected by Medicaid via a payment  
8 withholding from providers.

9 So that part is satisfied. It's  
10 the provider who is stuck collecting or not  
11 collecting, and we don't determine anyone's  
12 eligibility. So a person would never really lose  
13 eligibility because of nonpayment back to the  
14 provider; is that correct?

15 MS. CLARK: If your business model  
16 is to eat that cost, then that's each individual  
17 business model. But if you -- if they don't pay,  
18 and that's the requirement, and you are expected  
19 to collect that and you try, you need to -- a  
20 provider should report back to DCBS.

21 MR. CALLEBS: Okay.

22 MS. SMITH: It's essentially extra  
23 income when you think about it. So they could  
24 be -- so a couple things --

25 MR. CHRISTMAN: Oh, yeah.

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1 MS. SMITH: They could even be --  
2 have a higher patient liability as a result. So  
3 it would just make it easier on providers, or  
4 they could not qualify at all because of that  
5 extra income.

6 MR. CALLEBS: So it should be  
7 reported to DCBS that they're not paying?

8 MR. CHRISTMAN: So it sounds like  
9 it really needs to be collected?

10 MR. CALLEBS: It does.

11 MS. SMITH: It's important.

12 MR. CHRISTMAN: Yeah.

13 MS. SMITH: I have some -- I can  
14 give you all just some -- and I think, Johnny,  
15 this was something I was working on when we had  
16 met, just who this -- the numbers that it  
17 impacts. And I realize one person -- it's  
18 important to that person. But when you think  
19 about that we have -- we've got close to 24,000  
20 people enrolled in the waiver. We're looking at  
21 individuals that have a patient liability of 1  
22 dollar or greater, it's only 10 percent of that  
23 population.

24 And when you look at those that  
25 have a patient liability that is above \$500, it's

1 less than 1 percent of the total population. So  
2 you're going to hear, of course, from the ones  
3 that have that high amount because it, all of a  
4 sudden, is a huge change for them. But when you  
5 look at the scope overall, it's not that big a  
6 change. Most of these people have been paying  
7 their full patient liability.

8 MR. CALLEBS: And the less than  
9 1 percent of the total Medicaid population or the  
10 waiver population?

11 MS. SMITH: The waiver population.

12 MR. CALLEBS: The waiver  
13 population.

14 MS. SMITH: Of that 24,000 people.

15 MR. CHRISTMAN: Yes?

16 MS. SHELL: I agree that they're  
17 getting their money. Like as far as the less  
18 than this much is not that much. For the  
19 providers, though, we are not getting paid that  
20 patient liability in a lot of cases.

21 And so, even though Medicaid is  
22 still getting it, we're not. And there's nothing  
23 we can do. If we report it, and so, therefore,  
24 their patient liability gets higher, that's just  
25 less money the providers get.

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1 MR. CHRISTMAN: That's right.

2 MS. SHELL: So I mean, if -- it  
3 really is not helping us get that money back.  
4 And as a residential provider, if you say, okay,  
5 we're going to report it, they may not have this,  
6 then, what do you do? Because you have several  
7 individuals that you're losing quite a bit of  
8 money from, and you cannot do anything -- like,  
9 you can give a 30-day notice, but where are they  
10 going to go?

11 MR. CHRISTMAN: That's right.

12 MR. HARVEY: That led to a  
13 question that I just want to pose. Because we  
14 just had a KAPP call, a public policy call,  
15 whatever, where this policy was discussed, and  
16 there's a number of providers that were on that  
17 call that have indicated that they have been told  
18 that they can't terminate services because of  
19 nonpayment of patient liability.

20 I'm just wondering, you know, can  
21 you -- nonpayment of the patient liability, is  
22 that -- can you terminate a client over that or --  
23 not that I'm looking to terminate clients or  
24 anything. I'm just saying, providers' hands are  
25 tied, like she's saying. And you know, there's

1 very few options left to us to collect that. And  
2 it does seem a bit unfair that it's being paid for  
3 them, but it's being paid out of the providers'  
4 payment for services, not them as an individual or  
5 family payment.

6 MR. GRESHAM: So the way I see it,  
7 the provider has two choices: One, if it's their  
8 business model to continue paying --

9 MR. HARVEY: This business model  
10 of just eating that --

11 MR. GRESHAM: I understand --

12 MR. HARVEY: -- I don't know of  
13 any provider in the State that has a model that  
14 allows them to just eat money for something.

15 MS. KRIES: We have a few smaller  
16 day program agencies that have decided they don't  
17 want to even worry about if it's somebody that  
18 has a \$50 to \$100 -- they are just not going  
19 to worry about it.

20 MR. HARVEY: It's going to get  
21 long.

22 MS. KRIES: And then you pose the  
23 whole thing of, okay, well, is that going to be  
24 more about, I'm going to go to the services at  
25 the Y day program because they are not going to

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1 charge me because X day program is going to  
2 charge me? Then you've got -- basing upon who is  
3 going to actually make you pay your Medicaid  
4 liability, you know. That's -- if they're not  
5 charging it, then they still really don't have  
6 that extra income.

7 MR. CHRISTMAN: Right. We'll get  
8 to it probably not real soon, but it goes back to  
9 your point. It's really not in your interest to  
10 report it, is it?

11 MS. SHELL: Not at all.

12 MR. CHRISTMAN: That's what you  
13 are saying?

14 MS. SHELL: Not at all. It would  
15 not benefit me -- I am already losing tons of  
16 money because they are still eligible. We get it  
17 taken out of what we get repaid. So they're  
18 still eligible. Medicaid's --

19 MR. CHRISTMAN: Right.

20 MS. SHELL: We just -- in the  
21 process, we never see our money.

22 MR. CHRISTMAN: Right. Earl,  
23 what did you want -- you were going to say  
24 something? Our two options?

25 MR. GRESHAM: Yeah. The other

1 option is, if they don't pay their patient  
2 liability, they are voluntarily terminating  
3 themselves from the program because they are not  
4 meeting their requirement.

5 So you would do a program closure  
6 in MWMA. You need documentation that you tried to  
7 work with them. You've given them a cap, however  
8 you do that. You upload it at MWMA, their program  
9 closed. Then DCBS will review their Medicaid  
10 eligibility. And they will likely move out of  
11 Medicaid.

12 MS. SHELL: Even though they are  
13 still getting paid? Because it's coming out of  
14 the providers. That's the only little piece that  
15 I don't quite understand.

16 MS. KRIES: You're not  
17 understanding. If they are not paying you,  
18 they're drawing income -- they are not reporting  
19 to DCBS. So then they're technically not meeting  
20 that financial requirement --

21 MR. CHRISTMAN: Right.

22 MS. KRIES: -- because they have  
23 more income than this.

24 MS. SHELL: Are we going to have  
25 something out there that puts that in simple

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1 terms? Because that's not how it's understood.  
2 They don't understand the patient liability  
3 portion now.

4 MR. CHRISTMAN: So what you're  
5 saying, Earl, we're not terminating them; they're  
6 withdrawing from the program?

7 MR. GRESHAM: That's correct.

8 MR. CHRISTMAN: So yeah, we can't  
9 terminate them, but we don't have to terminate  
10 because they're withdrawing from the program?

11 MR. GRESHAM: Correct. They are  
12 not fulfilling their own responsibilities.

13 Now, it is more difficult in a  
14 residential situation --

15 MR. CHRISTMAN: Absolutely.

16 MR. GRESHAM: -- because then you  
17 have to evict them.

18 MS. SHELL: It is simply going to  
19 be a fine line between neglect and -- certain  
20 neglect and they're saying, yes, they're  
21 utilizing our services, but we are going to  
22 voluntarily terminate. What are we going to do  
23 with the person? As an agency, I don't know that  
24 I can do that. I don't want to lose the money  
25 we're losing, but I don't want to do --

1 MR. CHRISTMAN: Obviously, this  
2 other remedy is really important, if we can just  
3 reduce the patient liability.

4 MS. ELSTUN: I've went through  
5 some of my notes. And what we kind of suggest is  
6 the solution is looking at, maybe through  
7 Navigant redesign, is that the 1915(c)s, that the  
8 cabinet checks the box on the forms that would  
9 make a personal needs allowance. Three  
10 hundred percent of SSI rather than the current  
11 percentage lineups of 770; so 300 percent of SSI  
12 is 2,310. So for many people this would resolve  
13 the whole patient liability issue in paying.

14 MR. CHRISTMAN: And that can be  
15 done now?

16 MS. ELSTUN: I don't have an  
17 answer to that. Earl might be able to, or Lori,  
18 but I know that --

19 MR. CHRISTMAN: Yeah.

20 MR. GRESHAM: It requires --

21 MR. CHRISTMAN: Oh, okay.

22 MS. GRESHAM: I mean, it's a  
23 substantive change. So it would require the  
24 entire process.

25 MR. CHRISTMAN: Like public

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1 notice?

2 MS. GRESHAM: Everything. And if  
3 we did it now, it would require the entire  
4 process.

5 MS. BENTLEY: I just wanted  
6 to share that I was in the Behavioral Health TAC  
7 yesterday, and recommendations were made in the  
8 redesign to increase that amount to 300 percent  
9 of SSI. And then, also for the Consumer TAC,  
10 that was recommendations that they were talking  
11 about. So lots of other groups are having the  
12 same conversations.

13 MR. CHRISTMAN: Sounds like a good  
14 motion for us to make, too. Right?

15 MS. BROTHERS: I think we should  
16 make a motion.

17 MR. CHRISTMAN: So the motion  
18 would be something we need to make that we would  
19 increase the personal allowance for, what, waiver  
20 participants to 300 --

21 MS. COLLINS: Personal needs  
22 allowance, 300 percent of SSI.

23 MR. CHRISTMAN: -- 300 percent of  
24 SSI.

25 MR. HARVEY: I'll second the

1 motion.

2 MR. CHRISTMAN: Sherri, are you  
3 going to make it?

4 MS. BROTHERS: Yes, I make the  
5 motion.

6 MR. HARVEY: I'll second it.

7 MR. CHRISTMAN: Okay. Do we  
8 understand the motion? Do we need more  
9 discussion?

10 All in favor?

11 (All said Aye.)

12 MR. CHRISTMAN: Opposed?

13 (None.)

14 MR. CHRISTMAN: Okay. Let's go to  
15 the next agenda item then. That's a good motion.

16 Electronic Visit Verification  
17 Update. Now, this has like got everybody in the  
18 United States worked up. The last time we were at  
19 this meeting, you were defining this very  
20 narrowly, I thought, right? Has that changed  
21 or --

22 MS. GRESHAM: Not really. CMS put  
23 out a Frequently Asked Questions. And in that  
24 they said, no, residential is not included in  
25 this. Which -- and they said it that plainly,

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1 no, this is not about residential. That made me  
2 go ahhhhhh. So DMS is working with OATS to do  
3 our stakeholder. We're currently looking at how  
4 we're going to do our stakeholder feedback, get  
5 the plan together, work on education, and all of  
6 those things.

7 We're also working on requesting  
8 our extension, just like everybody else in the  
9 United States is requesting that good faith  
10 extension. We have gotten an informal, yes,  
11 you'll get an extension. But until it's written  
12 on paper, I don't believe it.

13 And so, we're just kind of in that  
14 process of planning. We've taken in a lot of  
15 information about what needs to be verified, how  
16 that looks, how you would have to do it, what CMS  
17 is requiring. There's still some gray areas with  
18 CMS that we hope that they will clarify.

19 But we're looking at what that  
20 looks like to our providers, what that looks like  
21 to our families, and how to get the information to  
22 them. First of all, what EVV is, because we've  
23 heard folks are scared that we're going to put a  
24 chip in their arm. And I have said, I can tell  
25 you Kentucky will not, for this initiative, be

1 putting a chip in your arm. We have not made a  
2 decision, but I can tell you that won't happen.

3 And so understanding that, one, for  
4 families, there needs to be education, and that  
5 will be part of the process as to what EVV is, why  
6 we're doing it. And then also getting feedback  
7 from providers about, do you currently have an  
8 EVV? If you do, what does that look like? Does  
9 that meet the requirements? If you don't, do you  
10 want to buy your own? Do you want us to do one?  
11 How providers would like that to look, what's the  
12 best way to kind of implement that system.

13 So we're working on that strategy  
14 of how to gather that information and how to work  
15 that plan through. So...

16 MR. CHRISTMAN: My understanding  
17 is this pertains to home health services, right?  
18 Is that --

19 MS. GRESHAM: It is for  
20 personal -- in-home personal care services by  
21 January of 2019 unless you get the good faith  
22 extension. It is in-home personal care services.

23 MR. CHRISTMAN: So what services  
24 in the, like, the SCL waiver --

25 MS. GRESHAM: PDS would be one.

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1 For SCL, that's mainly -- it's your PDS personal  
2 care services.

3 MR. CHRISTMAN: Like --

4 MS. GRESHAM: Personal assistance.  
5 Community access. Anything where your --

6 MR. CHRISTMAN: Oh, community  
7 access is --

8 MS. GRESHAM: -- is community  
9 access the right -- CMS defines it as anywhere  
10 where you're providing direct service in the home  
11 for --

12 MR. CHRISTMAN: In the home?

13 MS. GRESHAM: In the home for --  
14 in their natural environment --

15 MR. CHRISTMAN: Community access  
16 should not be among them, right?

17 MS. GRESHAM: Depending on  
18 the definition. I would have to look at the  
19 definition.

20 MR. CHRISTMAN: Are other states  
21 viewing this broader than this, or why --

22 MS. GRESHAM: Initially, when the  
23 Medicaid directors looked at it, they thought it  
24 included residential.

25 MR. CHRISTMAN: Okay.

1 MS. GRESHAM: It was a topic of  
2 discussion and CMS even kind of -- and Johnny and  
3 I have had that discussion, that when you read it  
4 the first time you're like, uh, is this in any  
5 home. And CMS has clarified that we don't mean  
6 paid residential. We mean their home.

7 MR. CHRISTMAN: So there's an  
8 extension, and it's still a relatively narrow  
9 definition?

10 MS. GRESHAM: Yes. So -- and for  
11 waivers, it's supposed to be, as I said,  
12 January 2019, except if you get the extension.  
13 And then for home health, that comes in 2022. So  
14 home health then has to pick up. And home  
15 health, it just says home health services. It  
16 doesn't specifically say personal care home  
17 health services. So that will be, I hope, better  
18 defined as that comes forward.

19 MR. CALLEBS: And then, just to  
20 further update, there's a bill working its way  
21 through Congress. It's passed the House and is  
22 in the Senate. And so we're looking to try to  
23 get the two senate leaders to try to pass it by  
24 unanimous consent vote.

25 So that, from what we hear, looks

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1 promising. Which would delay EVV by one year  
2 across the board. So that -- fingers crossed on  
3 that -- I think every state is asking -- wants  
4 more time to figure this out.

5 MS. GRESHAM: And most states that  
6 didn't already have an EVV are right where we  
7 are. What we've seen national -- the states that  
8 already had EVV in place, obviously, are  
9 flourishing and doing well. The system itself  
10 has saved -- the states that have implemented  
11 well, it has really helped with fraud and those  
12 kind of things.

13 So there's good models out there.  
14 Florida, in Dade County, had phenomenal success  
15 with EVV. So it's not that it's a bad -- it's  
16 just they said, do this, do it quickly. And I  
17 don't know that there was much forethought in the  
18 states' infrastructures. If you're in a metro  
19 area, it's pretty easy to do EVV and everybody's  
20 got internet connection and all of those things.

21 But to look at rural areas, not  
22 only do you have network inadequacy  
23 technology-wise, you have fear as well. And so  
24 doing education and all of those things, to me, is  
25 paramount for that to be a success.

1 MS. KRIES: Like respite?

2 MS. GRESHAM: If they provide  
3 personal care, then yes.

4 MR. CHRISTMAN: In the home?

5 MR. HARVEY: If it takes place in  
6 the individual's home?

7 MS. GRESHAM: If it's in the home.

8 MS. KRIES: Yes.

9 MR. CHRISTMAN: Any other  
10 questions or comments on that?

11 Waiver redesign. Have all of the  
12 public hearings been complete now?

13 MS. GRESHAM: The town halls, yes.

14 MR. CHRISTMAN: The town halls.

15 MS. GRESHAM: Uh-huh. Public  
16 comment for the recommendations specifically  
17 ended on June 15th. Navigant will be submitting  
18 a final report to the Cabinet. The Cabinet will  
19 then work to determine what recommendations we'll  
20 move forward with. And then we'll distribute the  
21 information to the stakeholders about, here's the  
22 recommendations, here's what that may look like,  
23 and have those conversations again.

24 MR. CHRISTMAN: And those kind of  
25 conversations will take place in a different kind

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1 of -- I mean, how will those be determined?

2 MS. GRESHAM: We haven't  
3 determined that yet.

4 MR. CHRISTMAN: Haven't been  
5 determined yet.

6 What's, again, a goal?

7 MS. GRESHAM: Hopefully, by the  
8 end of summer.

9 MR. CHRISTMAN: For the --

10 MS. GRESHAM: For the final  
11 report, yes.

12 MR. CHRISTMAN: Going public?

13 MS. GRESHAM: Yes.

14 MR. CHRISTMAN: And then there  
15 would be some mechanism --

16 MS. GRESHAM: Conversation.

17 MR. CHRISTMAN: -- for comment?  
18 Right?

19 MR. CALLEBS: The final report  
20 would contain the recommendations that may be  
21 tweaked and --

22 MS. GRESHAM: Right. If you  
23 remember in the town halls, Navigant talked  
24 about, based on public comment and those kind of  
25 things, they would go back and look at their

1 recommendations and they may tweak some of those  
2 some, and that final report of here's what  
3 Navigant says would come out.

4 MR. CHRISTMAN: I don't know how  
5 difficult it would be, but I think a lot of  
6 people would like to see more of a back and forth  
7 Q and A on this second round. Right?

8 MS. BROTHERS: I think so.

9 MR. STEVENSON: Yes.

10 MR. CHRISTMAN: Any other  
11 comments on that?

12 MR. CALLEBS: Lori, when the  
13 recommendations come out, so that will be -- did  
14 you say that will start another round of just  
15 like town halls or forums?

16 MS. GRESHAM: Something.

17 MR. CALLEBS: Something --

18 MS. GRESHAM: Some way to -- we  
19 can --

20 MR. CALLEBS: -- for public input?

21 MS. GRESHAM: Uh-huh.

22 MR. CALLEBS: For stakeholder  
23 input? And then, could they change again?

24 MS. GRESHAM: The recommendations  
25 won't, no. That will be Navigant's final report

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1 of recommendations.

2 MR. CALLEBS: And then public  
3 comment will be made on those, and then going  
4 forward --

5 MS. GRESHAM: And the planning --

6 MR. CALLEBS: But then Navigant  
7 will be through with their recommendations, but  
8 Medicaid would still make some changes based on  
9 public --

10 MS. GRESHAM: Right. Then the DMS  
11 would decide, okay, here's the recommendations we  
12 want to go with, here's what that kind of looks,  
13 and, you know, really having a little more  
14 information about what that means in Kentucky.

15 MR. CHRISTMAN: Very likely there  
16 would be changes to regulations, correct?

17 MS. GRESHAM: Absolutely.

18 MR. CHRISTMAN: Very, very likely?

19 MS. GRESHAM: Waivers and  
20 regulations.

21 MR. CHRISTMAN: Right. The  
22 Community Setting Rule Update. I think last time  
23 you had like 300 settings that were heightened  
24 scrutiny, and you had gone through a review  
25 process or submitted a hundred of those with your

1 recommendations to the federal --

2 MS. GRESHAM: No, we submitted 40  
3 something --

4 MR. CHRISTMAN: Oh, not that many.

5 MS. GRESHAM: No.

6 MR. CHRISTMAN: You reviewed 40 --  
7 a hundred, but you haven't submitted those to the  
8 federal government?

9 MS. GRESHAM: Correct. So we're  
10 still waiting on CMS to give us conversation  
11 about the ones we've already submitted. We've  
12 heard nothing. They keep telling us soon, soon,  
13 soon. And as we know, until they say very soon,  
14 soon means nothing. And so we've submitted that  
15 initial. We continue to work towards reviewing  
16 all of those provider packets.

17 MR. CHRISTMAN: So it's more than  
18 a hundred now that you've reviewed or --

19 MS. GRESHAM: Not yet, because we  
20 haven't had another stakeholder.

21 MR. CHRISTMAN: Oh, okay. Right.

22 MS. GRESHAM: We sent out  
23 communication last week or the week before about  
24 the next review process, and that's on July 30th.  
25 We've had, I want to say, four or five

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1 self-advocates or their family members that have  
2 responded. So very few.

3 And we're also, on August 15th,  
4 having an informational webinar about the rules  
5 and the next set of rules and kind of what that  
6 looks like. And that will be via webinar. So  
7 we're just continuing to work towards our  
8 transition plan.

9 One of the things that we have  
10 discussed is going ahead and submitting the  
11 settings that we've reviewed in our stakeholder  
12 meetings. Otherwise, we're really just sitting  
13 around waiting for input. So that's kind of in  
14 our next big discussions. Do we wait for CMS? Do  
15 we go ahead and put the next round in?

16 MR. CALLEBS: Did you say 40 have  
17 been submitted last year?

18 MS. GRESHAM: Forty-three or  
19 something like that.

20 MR. CALLEBS: Forty something,  
21 yeah, and no response?

22 MS. GRESHAM: No response  
23 whatsoever.

24 MR. CHRISTMAN: But you have  
25 reviewed a hundred, right?

1 MS. GRESHAM: A hundred plus.

2 MR. CHRISTMAN: Have you made a  
3 decision on any of them -- have you found any of  
4 them to be non-community based of that 100?

5 MS. GRESHAM: We won't -- no.  
6 Until --

7 MR. CHRISTMAN: I mean, your  
8 recommendation.

9 MS. GRESHAM: There are some that  
10 the stakeholders have said this transition plan  
11 is not ready to send to CMS. And then we work  
12 with that provider to say, here are areas that we  
13 continue to see that this didn't meet the  
14 requirements of the final ruling, and working  
15 with those providers specifically to help them  
16 get their business in conformance.

17 MR. CHRISTMAN: So what your  
18 desire is before you submit them to the federal  
19 government, that you believe that they're --

20 MS. GRESHAM: CMS says it must be.  
21 We can't submit it until we believe that they are  
22 in compliance, or have a plan to be in  
23 compliance.

24 MR. CHRISTMAN: So all settings  
25 will be in compliance?

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1 MS. GRESHAM: For us. We will  
2 look at them and say, your transition plan  
3 supports the federal --

4 MR. CHRISTMAN: And the federal  
5 government may then decide, no, that's not  
6 adequate.

7 MS. GRESHAM: Correct.

8 MR. CALLEBS: Can I ask one  
9 particular question about the final rule of  
10 heightened scrutiny? I know one requirement is  
11 signed leases by people who get residential  
12 support.

13 MS. GRESHAM: Correct.

14 MR. CALLEBS: And I know providers  
15 have to have a plan to do that, but the actual  
16 required date to have them in place and signed,  
17 is that --

18 MS. GRESHAM: Yes. So we have  
19 submitted to CMS our transition plan, and it's  
20 got approval. So we've said that CMS says that's  
21 what you have to abide by. So ours is March of  
22 2019. That's when our -- all of those things  
23 will go in with the next generation of waivers  
24 and regulations, because that's what we've told  
25 CMS that we're trying to get.

1                   Now, Kentucky's plan for that is,  
2   we have them in regulation. We won't start  
3   compliance actions like moratoriums or anything  
4   based solely on that until that 2022. There is  
5   some magical extension. There's not a whole lot  
6   of conversation, but that is our intention, is  
7   that we will have a new regulation and we expect  
8   providers to be working towards that beginning  
9   with that.

10                  But we won't terminate anybody and  
11   say you're not a home and community-based provider  
12   because you are not following the rules until  
13   2022.

14                  MR. CALLEBS: Until 2022. Will  
15   you cite providers for that prior to and just  
16   not -- or you're not going to enforce it at all  
17   until 2022?

18                  MS. GRESHAM: If it's in  
19   regulation, then we would have to cite them, yes.

20                  MR. CALLEBS: Okay. But that  
21   wouldn't even start until March of '19.

22                  MS. GRESHAM: Correct, until it's  
23   in regulation.

24                  MR. CALLEBS: Okay. And I know  
25   providers are trying to -- a lot of providers are

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1     trying to come in compliance with that or really  
2     get serious about it. One barrier is that state  
3     guardianship will not sign any of those. So  
4     that's a substantial population supported in SCL,  
5     in particular. So they're not signing any of  
6     them. So no matter how, you know, particular it  
7     is and how -- you know, if it's undergone legal  
8     review and the whole nine yards, they are just  
9     not signing. So...

10                   MS. GRESHAM: Could you have  
11     somebody send me a copy of one that -- the best  
12     one that state guardianship has said, we're not  
13     signing that, just so we can start having those  
14     conversations?

15                   And it may be that state  
16     guardianship just doesn't understand the  
17     requirement. So we can provide some education and  
18     kind of look at that barrier and see.

19                   MR. CALLEBS: Sure.

20                   MR. HARVEY: And being fair to  
21     state guardianship, they haven't indicated that  
22     they won't sign it. They just indicated that  
23     this doesn't go into play until 2019, and they've  
24     got until then to -- but I'm kind of with Johnny  
25     on this. I think we need to be getting them

1 signed now rather than waiting until 2019 gets  
2 here to get them signed.

3 Because they're basic residential  
4 agreements/leases, whatever you want to call them.  
5 Some organizations call them residential  
6 agreements because that's what the final rule  
7 calls them. And some people call them leases and  
8 things of that nature. So...

9 MR. CHRISTMAN: I mean, what do  
10 you hear from your colleagues around the United  
11 States? It sounds like we're not making a whole  
12 lot of progress -- the federal government is not  
13 making much progress on this.

14 MS. GRESHAM: You know what,  
15 there have been a few more states that have  
16 gotten final approval, but it's still -- it's  
17 still missing the digits of states who have  
18 gotten final approval of their transition plan.

19 MR. CHRISTMAN: Let alone  
20 submitted transition plans from --

21 MS. GRESHAM: From settings.

22 MR. CHRISTMAN: -- yeah, settings.

23 MS. GRESHAM: And so Kentucky is  
24 kind of at the forefront, and that's a good and a  
25 bad, because we're waiting to see what they say.

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1 MR. CHRISTMAN: Because over all  
2 the United States there's going to be thousands  
3 and thousands.

4 MS. GRESHAM: Yes. In California  
5 alone they talked about thousands of settings. I  
6 mean, initially, as I've told you all, CMS said,  
7 we're going to visit every setting, and then  
8 they're like, uh, nope.

9 And that's one of the reasons that  
10 they said before we send them, the state has to  
11 determine that they believe that that provider is  
12 in compliance, because there's just no way for  
13 them to visit every setting.

14 MR. CHRISTMAN: So you would  
15 guess they're probably going to take the  
16 states --

17 MS. GRESHAM: No idea. I don't  
18 want to even begin to do that. And they said  
19 they will look at a sampling and determine based  
20 on that sampling.

21 MR. CHRISTMAN: I see.

22 MS. GRESHAM: And so I don't want  
23 to even pretend to guess what they will do or not  
24 do.

25 MR. CHRISTMAN: Okay. Medicaid

1 Innovation Accelerator Program. Did I see  
2 something that Kentucky has been selected to  
3 participate in this?

4 MS. GRESHAM: We are.

5 MR. CHRISTMAN: Talk about what  
6 that means.

7 MS. GRESHAM: Sure. Medicaid has  
8 several tracts that are called innovative  
9 accelerator programs, and they are TA, technical  
10 assistance, tracts that CMS puts on with a very  
11 select group of states.

12 Kentucky put in an application  
13 for -- they are called IAPs for value based  
14 payment. As part of the redesign, one of  
15 Navigant's recommendations is a rate study, and  
16 we've been very frank in understanding that that  
17 likely needs to happen. And part of that would be  
18 looking at value-based payments and incentivizing  
19 quality through payment mechanisms that are based  
20 on value rather than based on compliance.

21 And so Kentucky was one of ten  
22 states that was selected to do that. We're  
23 working with CMS to learn about this opportunity  
24 and how Kentucky may be able to use those  
25 value-based payments.

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1                   Nationally, fee-for-service states  
2    doing value-based payments, and doing it well, is  
3    slim to none. There are -- most value-based  
4    payments go through MCOs, and the MCOs get the  
5    enhanced payments, and then they send that out to  
6    do things like that -- and are able to do those.

7                   Very few states have any  
8    value-based payments based in a fee-for-service  
9    model. And there are five or six states that are  
10   fee-for-service based states in this IAP. And so  
11   it's very exciting to be one of the states that is  
12   really looking at doing this well on a  
13   fee-for-service environment. So...

14                  MR. CHRISTMAN: So is Navigant --  
15   they're looking at a fee review rider --

16                  mrs. gresh: One of the  
17   recommendation is to --

18                  MR. CHRISTMAN: -- so does that  
19   imply that we're going to stay with a fee-based  
20   mechanism?

21                  MS. GRESHAM: Currently, that --  
22   as we've said, there is no plans to even begin to  
23   look at the restructuring until phase two.

24                  MR. CHRISTMAN: Right.

25                  MS. GRESHAM: We don't have enough

1 data to even look to say what's the best way to  
2 do it. So...

3 MR. CHRISTMAN: Yeah. So let's  
4 assume -- yeah, so it's going to stay fee based.  
5 What's an example of a value-based fee thing?

6 MS. GRESHAM: So one of the models  
7 that they have talked about -- and again, there's  
8 not any good examples of fee for service. But  
9 one of the things that you look at is, looking at  
10 data. For instance, hospital readmissions for  
11 individuals who go to the ER. Have those  
12 decreased, and looking at kind of the whole  
13 person, and looking at hospital admissions and  
14 value in that. Looking at care plans and how  
15 successful those have been.

16 And, of course, all of those are  
17 very -- you would have to have very strict  
18 guidelines as to what that is. But it's just  
19 looking at selecting an area that you want to  
20 enhance the value of that area, and having a  
21 payment structure tied to that to enhance the  
22 increase of quality services in whatever areas.

23 MR. CALLEBS: For example, if you  
24 want to focus on employment and people's  
25 disabilities, and then you could have value-based

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1 payments for providers --

2 MS. GRESHAM: Successful  
3 employment or something.

4 MR. CALLEBS: Right. If a person  
5 is successfully employed, then it can be an  
6 enhanced value-based payment to the provider for  
7 having the person achieve that.

8 MS. GRESHAM: Right.

9 MR. CANNON: And maintain it,  
10 would be one example.

11 MR. CHRISTMAN: So does the  
12 federal government want you to have a plan for  
13 that by a deadline?

14 MS. GRESHAM: This IAP does not  
15 have a deadline. We have a deadline of when the  
16 IAP tract ends. They have indicated that we're  
17 not required to have a value-based payment even  
18 at the end of it.

19 Because it is so new for  
20 fee-for-service, a lot of the states are looking  
21 and saying, can you even do a fee-for-service  
22 value-based payment. And so the expectation of  
23 CMS is not that you have to have a value-based  
24 payment at the end of this. If you do, fantastic.  
25 But it's not a requirement.

1                   MR. CALLEBS: Will they be just  
2   kind of working -- coming in state and working  
3   with the Department to look at infrastructure and  
4   systems and what to --

5                   MS. GRESHAM: Right. We'll set up  
6   what's called a technical assistance plan to say,  
7   here's what we're looking at value-based  
8   payments. They will then help us to know, here's  
9   how you would get the data for that, here's how  
10   you -- they will really just kind of guide us in  
11   that. And yes, they'll come on site and sit down  
12   and talk with us and things like that.

13                  They are very understanding that  
14   we're going through a redesign and not making us  
15   do double work. So there's stuff that's already  
16   been pulled, they'll utilize that, that kind of  
17   thing. So, yeah, it's really state specific and  
18   what the state wants from that model.

19                  MR. STEVENSON: What are the other  
20   states that are doing this?

21                  MS. GRESHAM: Washington was  
22   one --

23                  MR. GRESHAM: Hawaii.

24                  MS. GRESHAM: -- Texas. Hawaii  
25   was one. What did you say? Yeah, we all wanted

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1 to be the ones that drew the straw to go to  
2 Hawaii. Alabama or Arkansas, one of the two.

3 MR. GRESHAM: Texas.

4 MS. GRESHAM: Texas. A couple of  
5 New England states. But it's on their website,  
6 the ten states that are --

7 MR. STEVENSON: So the part to going  
8 through this phase one, what is that -- I mean,  
9 what are we talking about this could potentially  
10 be?

11 MS. GRESHAM: The value based? I  
12 really don't want to do -- because I don't want  
13 to give you false hope or expectations. It just  
14 depends on what we learn from that as to how  
15 successful it could be implemented in Kentucky.

16 So I don't want to give you a date  
17 that -- the rate study itself, should we choose to  
18 accept that recommendation, will start likely  
19 towards the end of summer.

20 MR. CHRISTMAN: Well,  
21 congratulations!

22 MS. GRESHAM: Thank you. Our team  
23 has worked very hard, doing lots of things.

24 MR. CHRISTMAN: Now you get to do  
25 more work.

1 MS. GRESHAM: Yeah. Johnny jokes  
2 with me, I have meetings with janitors.

3 MR. CHRISTMAN: Okay. SCL and  
4 Michelle P Waiting Lists.

5 MS. CLARK: Sure. There are  
6 currently 2,367 people on a future waiting list,  
7 and there are 142 in the urgent category waiting  
8 list. And at this time, we have 103 available  
9 slots.

10 And for Michelle P Waiver, we have  
11 6,576 total on the waiting list, and 68 percent of  
12 those are under the age of 21.

13 MR. CHRISTMAN: And you still have  
14 open slots, correct?

15 MS. CLARK: Yes. We are getting  
16 ready to take a look at -- we're not through the  
17 process because we allocated some at the  
18 beginning, and we have to wait for the appeal  
19 processes to come in.

20 MR. CHRISTMAN: The last time you  
21 counted, how many slots were open?

22 MR. GRESHAM: Roughly, 400.

23 MR. CHRISTMAN: And the waiting  
24 list, like since the last time we spoke, you're  
25 still going through that list?

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1                   MR. GRESHAM: We're still working  
2 on it. We're having to refine some processes as  
3 we go, but we're working on it.

4                   MR. CHRISTMAN: And you're finding  
5 a lot of the people on the list are not eligible?

6                   MR. GRESHAM: We're actually  
7 finding a lot of people don't want to be on the  
8 list, which is nice, because that's -- then we're  
9 not worried about an appeal. So that's been  
10 pleasantly surprising.

11                  MR. CHRISTMAN: I know the last  
12 time we had our membership meeting we said that,  
13 I think the numbers we used, like 10 percent of  
14 the people on the list actually end up being  
15 eligible and a lot of people are just shocked by  
16 that because I think they -- there's a lot of  
17 people help submit names to the list, and they  
18 felt like they had been vetted. But apparently,  
19 there's a lot of people who have just been added  
20 to the list kind of willy-nilly, right?

21                  MR. GRESHAM: When we started the  
22 waiting list, and we created that process, the  
23 requirement and regulation was only that you  
24 submit a MAP 621. There was no requirement that  
25 you had IDD. There was no requirement of

1 anything, even if it got to the point where the  
2 max was 21, did not necessarily have all the  
3 information on it, but they still put them on the  
4 wait list.

5 So there were agencies -- case  
6 management agencies that were going out, putting  
7 people in a circle saying, here, sign this. We  
8 have reports of that.

9 So yes, there's a lot of people on  
10 there, especially the first probably 3,000 at this  
11 point probably don't want to be.

12 MR. CHRISTMAN: Right. And so if  
13 we say it's like one in ten end up being  
14 eligible, that sounds about right?

15 MR. GRESHAM: Maybe.

16 MR. CHRISTMAN: Less than one in  
17 ten? Certainly not more than one in ten?

18 MR. GRESHAM: No. We have issued  
19 probably around 3500 slots in the last three or  
20 four years, and we have managed to increase by  
21 about 100.

22 MS. CLARK: Some of them go to SCL  
23 or something. There might be movement to SCL,  
24 but...

25 MR. CHRISTMAN: So again, that

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1 explains the paradox of having a waiting list and  
2 having open slots. Right?

3 MR. GRESHAM: Right.

4 MS. BROTHERS: I just want to make  
5 a comment about that. I still feel that there  
6 are families out there who are on this waiting  
7 list -- because I hear about them every day, and  
8 I'm out there working with these families in  
9 these communities -- and they are on these  
10 waiting lists, and they exist, and they're real.  
11 And they've been waiting for a long time.

12 MR. GRESHAM: Yes, absolutely.

13 MS. BROTHERS: And they do have a  
14 disability.

15 MR. GRESHAM: Absolutely. And we  
16 want to get to them.

17 MS. BROTHERS: Yes, and I want you  
18 to get to them, too, because they've been waiting  
19 a long time. Over a year.

20 MR. CHRISTMAN: And did you say  
21 you're changing the protocol to maybe speed up  
22 the process, or did I understand you correctly  
23 that you're --

24 MR. GRESHAM: I said we're  
25 refining the process and trying to figure out how

1 to make it work faster.

2 MR. CHRISTMAN: So, yeah, you're  
3 trying to get through that waiting list faster.

4 MR. GRESHAM: Right.

5 MS. BROTHERS: What are you doing  
6 with that, redefining? Can you explain that to  
7 me?

8 MR. GRESHAM: We are -- yeah.  
9 We're looking at the process of, first of all,  
10 the nurses doing work -- we have nurses that are  
11 reviewing those and we have had some stumbling  
12 blocks where the nurses, we had to pull them out  
13 for other projects, other things came up. So  
14 we're trying to get to the designated team to do  
15 nothing but these assessments so that we can work  
16 through them.

17 MR. CHRISTMAN: So you're  
18 increasing the resources you're applying to this  
19 effort, right?

20 MR. GRESHAM: We're trying to.

21 MR. CHRISTMAN: Trying to.

22 MR. CALLEBS: Can I ask a question  
23 about -- in the meantime -- obviously, I'm not  
24 sure of the focus on this. But in the meantime,  
25 do people still come onto the waiting list --

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1 MR. GRESHAM: Yes.

2 MR. CALLEBS: -- in mass? Is  
3 there any refinement to how you can even get on  
4 the waiting list?

5 MR. GRESHAM: They're coming on  
6 the wait list, yes. And they're applying through  
7 MWMA, and they're selecting if they have an IDD  
8 and a waiver application to get there. And then,  
9 once it actually is chosen, it has to be  
10 reviewed. Are we requesting documents or --

11 MS. SMITH: Yeah.

12 MS. CLARK: If further information  
13 is needed, they are requesting further  
14 documentation.

15 MR. CALLEBS: Okay.

16 MS. BROTHERS: And what  
17 assessment is used?

18 MR. GRESHAM: 351.

19 MS. BROTHERS: 351.

20 MR. GRESHAM: We're also  
21 discussing with legal to see if there's faster  
22 ways that we can do what we're doing.

23 MR. CHRISTMAN: In the Navigant  
24 recommendation, I think there was like a  
25 pediatric assessment tool -- we talked about this

1 many times. So is there one?

2 MS. GRESHAM: So, nationally, is  
3 there an accredited pediatric tool? Not that's  
4 substantial. There are a few, like I think the  
5 IPAC has a pediatric component. Most of the --  
6 they did a survey of all 50 states and the  
7 tools -- I think 48 states use homegrown tools,  
8 which is what our 351 is. So having a good  
9 validated tool -- there may be validated tools  
10 out there, but most of them are still very state  
11 specific.

12 And so the long and short, yes,  
13 there's tools. Will they work for Kentucky? I  
14 don't know.

15 MR. CHRISTMAN: But we could  
16 develop our own?

17 MS. GRESHAM: Yes.

18 MR. CHRISTMAN: So it doesn't have  
19 to be -- does it have to be validated?

20 MS. GRESHAM: CMS likes them to be  
21 validated, but it is not required.

22 MR. CHRISTMAN: So what are we  
23 working on? So are we -- Kentucky, are we  
24 actively working to develop one?

25 MS. GRESHAM: We're trying to

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1 determine if we're going to -- our first step is  
2 to determine, are we going to accept the  
3 recommendation of a universal assessment tool.  
4 So there's conversations about that, with time,  
5 money, resources, all of those things. So I  
6 don't know yet is the answer.

7 MR. CHRISTMAN: Well, I think we  
8 should have a motion recommending we develop a  
9 pediatric assessment tool.

10 MS. BROTHERS: I make a  
11 recommendation.

12 MR. CHRISTMAN: Can we do that as  
13 a motion then --

14 MS. BROTHERS: Yes.

15 MR. CHRISTMAN: -- that Kentucky  
16 develop its own pediatric assessment tool. Would  
17 that be specific for the Michelle P Waiver or --  
18 certainly for the Michelle P Waiver. We've got  
19 68 percent of the kids on here are -- I mean, of  
20 the people on the waiting list.

21 MR. HARVEY: We made that motion  
22 four or five years ago.

23 MR. CHRISTMAN: Well, let's do it  
24 again. I didn't realize -- I thought we had to  
25 find one. I didn't realize we could make our

1 own.

2 MR. STEVENSON: Well, my  
3 understanding is that there were some families  
4 who were going to be included, and many of them  
5 thought that there was going to be concern about  
6 disqualification and they may have decided to not  
7 be involved. Is that correct? Evidently, it  
8 fell apart.

9 MR. GRESHAM: There was a while  
10 back that ECU was going to do a study. I believe  
11 they had a thousand recipients that they were  
12 going to do an ICAP -- was it the ICAP --

13 MR. STEVENSON: Yeah.

14 MR. GRESHAM: -- assessment and we  
15 had, I believe, either five or ten --

16 MS. BROTHERS: But if we have a  
17 say in what we're developing -- right, we're  
18 developing?

19 MR. CHRISTMAN: And other states  
20 have. I realize they're not -- the people -- the  
21 kids who live in these other states can't be that  
22 much different than the kids who live in  
23 Kentucky.

24 MR. STEVENSON: What we can do is  
25 make the motion and have them look at it and

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1 develop a solution. And just keep on --

2 MR. CHRISTMAN: And bring in some  
3 other assessments from other states, and do this  
4 in an expedited manner.

5 MR. STEVENSON: Yeah.

6 MR. CALLEBS: Until you do, I  
7 mean, you really can't -- it's hard to go forward  
8 and plan because of the 6,576 people known to be  
9 on the wait list. There's absolutely no way to  
10 know how many, if any, qualify or are ineligible  
11 for it, because of the assessment.

12 MR. CHRISTMAN: Yeah.

13 MR. STEVENSON: So they're busy  
14 trying to find staff to expedite this, when  
15 really the entry point needs to be fixed?

16 MR. CHRISTMAN: I'm not sure if I  
17 follow your point.

18 MR. CALLEBS: Well, just until you  
19 get a few assessments, you're never going to know  
20 it --

21 MR. CHRISTMAN: But it's important  
22 to get this done; that's what you're saying?  
23 It's important to get this done as soon as  
24 possible.

25 And again, I was always under the

1 impression we were looking for a national  
2 assessment. I didn't realize states could develop  
3 their own and it did not necessarily have to be  
4 validated. And other states have developed  
5 pediatric assessments. So why not us?

6 MS. BROTHERS: My concern is that  
7 we develop the right assessment. We don't  
8 eliminate people for certain reasons,  
9 especially ones with autism.

10 MR. CHRISTMAN: Right, right.

11 MR. STEVENSON: -- we can  
12 certainly suggest that the TAC be involved.

13 MS. BROTHERS: That's right. I  
14 would rather be involved in developing that tool.

15 MR. STEVENSON: So we could  
16 specifically make a motion that the TAC be a  
17 participant or a coauthor of a new pediatric  
18 assessment tool, or whatever assessment tool is  
19 appropriate to allow people to be on the Michelle  
20 P waiting list.

21 I don't know if you need to call it  
22 a pediatric assessment tool. You're simply  
23 wanting a mechanism for people to get onto the  
24 Michelle P Waiver. Pediatric assessment tool is  
25 their own. It just removes kids from it. You

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1 know, they need to be adults, they need to be  
2 whatever age. So that would be part of the  
3 ongoing discussion.

4 MS. POOLE: So across the  
5 lifespan?

6 MR. STEVENSON: Yeah. Sure. We  
7 just need to be able to get people to the table  
8 to have this discussion and say, this has gone on  
9 long enough, can we talk about the components of  
10 this tool, this assessment tool. So whatever  
11 that --

12 MR. CHRISTMAN: Do you think that  
13 should be the responsibility of the TAC to  
14 develop that?

15 MR. STEVENSON: No, to be -- to  
16 provide guidance and input.

17 MS. BROTHERS: Input.

18 MR. STEVENSON: Not our  
19 responsibility. Someone still needs to lead it  
20 and take control of it. But we certainly need to  
21 be at the table.

22 MR. CHRISTMAN: Well, it needs to  
23 be developed and brought to us. It hasn't been  
24 developed yet. Right?

25 MR. STEVENSON: It's either that

1 or we look at other states that are doing it.

2 MR. CHRISTMAN: Yes, that would be  
3 among the things, but this TAC is not going to  
4 develop it. I think the motion should be that we  
5 encourage the Department to develop a proposed  
6 assessment expeditiously, including looking at  
7 what other states are doing.

8 MR. STEVENSON: And I guess my  
9 point is, we're happy to sit at the table to help  
10 and guide, whether it's providers or whoever. It  
11 doesn't necessarily have to be the TAC.

12 MR. CHRISTMAN: Does somebody  
13 want to make a motion? Do you want me to?

14 MS. BROTHERS: You can.

15 MR. CHRISTMAN: That the TAC  
16 recommends that the Department expeditiously  
17 develop a pediatric assessment tool, including  
18 research on what other states have done in  
19 developing such an assessment.

20 MR. STEVENSON: I second that.

21 MR. CHRISTMAN: Any other  
22 discussion?

23 All in favor?

24 (All said Aye.)

25 MR. CHRISTMAN: Opposed?

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1 (None.)

2 MR. CHRISTMAN: Carewise Backlog  
3 and Process Changes. I didn't have that on the  
4 agenda.

5 MR. CALLEBS: I'll make an opening  
6 statement about it. As the Executive Director of  
7 KAPP, I've been getting frequent emails and  
8 concerns just about plans being backlogged and  
9 Carewise taking a long time to get approval,  
10 getting PAs issued, getting LOIs that are sent  
11 out, which further delays approval. So for some  
12 reason there is some sort of backlog in Carewise.  
13 Maybe it's unclogged by now.

14 But in addition to that, there was  
15 some apparent process changes on purchasing  
16 equipment and supplies, things like that, that  
17 were not known or announced or made known to  
18 providers or case managers. And so that when  
19 these requests go through, they get denied, LOIs  
20 get issued, and then their provider or case  
21 manager are referred to other lists or other  
22 sources to go redo their requests, and then having  
23 trouble finding those.

24 So it's just kind of some confusion  
25 about getting plans and services and supplies

1 approved in a timely manner so that people are  
2 left waiting and sometimes, frankly, doing without  
3 when they are entitled and should be getting the  
4 needed supplies.

5 So I just wanted to bring that up  
6 for discussion and see if there's a way to improve  
7 that, or is there something that we can all do to  
8 better educate case managers or providers about  
9 the process or just improve the communication  
10 around all that.

11 MR. GRESHAM: The Carewise  
12 backlog, there is a backlog. It's still  
13 backlogged. Part of that is due to MWMA issues  
14 that we're having.

15 MR. CALLEBS: Okay.

16 MR. GRESHAM: Those are being  
17 worked on by both the DXC team and the Deloitte  
18 team to get those resolved. The system has gone  
19 down a few times, actually several times, while  
20 they were trying to work tasks.

21 Part of it was taking on the  
22 additional responsibility of reviewing Michelle P  
23 PDS. That -- we gained 7,000 members when that  
24 happened, and so that kind of put them behind  
25 beginning in May. We're catching up with that.

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1 We work with them, all three parties, daily -- us,  
2 OATS, DXC, and Deloitte to try to ensure that  
3 those backlogs are getting taken care of.

4 When Carewise is making a  
5 determination of PA and the PA being approved,  
6 it's being approved back to the day it was  
7 submitted, without any followups submitted or  
8 anything like that. So that's to help speed that  
9 along.

10 MR. CALLEBS: I was just going to  
11 clarify. So the Michelle P PDS participants,  
12 there are 7,000 of those. So when the waiver  
13 changed, went to PDS and Michelle P and all of  
14 those had to come in and be approved or --

15 MR. GRESHAM: They started being  
16 approved, yes. Prior to that, I had staff that  
17 would review budgets based on historical  
18 knowledge to determine whether -- how much of a  
19 budget those people should get.

20 MR. CALLEBS: Sure.

21 MR. GRESHAM: And then it went to  
22 Carewise. It was a much longer, drawn-out  
23 process. It took a lot longer time. Now,  
24 Carewise reviews it and approves everything I  
25 send them.

1 MR. CHRISTMAN: Does that answer  
2 your questions about goods and services?

3 MS. BROTHERS: I have a question.  
4 My feeling is that, you know, the providers and  
5 the families, it just seems like to me that to  
6 making all of this easier, it's making it harder  
7 on them. Because the goods and the services,  
8 this is an area where they're actually able to  
9 get services that they need.

10 And now the providers are having to  
11 go through all this extra red tape it seems. And  
12 if they are denied through the state, then they're  
13 having to find, it says, three different -- they  
14 have to submit three quotes for goods and services  
15 or medical equipment not listed on the fee  
16 schedules -- I mean, they have to do all these  
17 things.

18 So if they have all of these  
19 different individuals that they're having to do  
20 all this for, how are they servicing the  
21 individuals better, is my question?

22 MR. GRESHAM: The reason they  
23 are -- the reason that the recipients are having  
24 to look at either home health or PDA to get their  
25 supplies or the DME side is because it's a

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1 different pool of money. Waivers are payers of  
2 last resort. We're paying out funds to pay for  
3 state plan services that we should not be giving.  
4 So this is to get that back in line to where the  
5 right money is paying for the right stuff.

6 It's also less of an impact on the  
7 provider because previously the support brokers  
8 would send in a budget, the budget would be based  
9 on historical data and was typically low,  
10 especially if you looked at ABI. Then the  
11 recipient would get the budget, but it wouldn't be  
12 enough to cover the goods. So they would have to  
13 request them.

14 Subsequently, it would be sent to  
15 DAIL. DAIL would review it. If there was  
16 something that wasn't there, we would send it back  
17 to the support broker until it was correct. Then  
18 DAIL would submit it to us. We have 30 days to  
19 look at it. We try to do it faster. Sometimes we  
20 could, sometimes we couldn't.

21 We would accept or deny the budget  
22 request. And then it would go back to the support  
23 broker and DAIL, and the support broker would be  
24 required to send it to Carewise. Now it goes from  
25 the recipient and the support broker to Carewise.

1 MS. BROTHERS: But are they  
2 trained on this? I mean, are the individuals  
3 going without the services while all of this is  
4 taking place?

5 MR. GRESHAM: They are  
6 continuing -- the plan of care is that -- or the  
7 person's plan is able to be done 60 days out. So  
8 if the providers -- if the case managers, support  
9 brokers are doing that 60, 45 days out, then yes.  
10 Because they are submitting that plan of care,  
11 they're getting it in early, and yes, they're  
12 still receiving the services.

13 MS. BROTHERS: There just seems  
14 like there's a lot of problems.

15 MR. GRESHAM: Any time there's  
16 change, we run into all kinds of road blocks, and  
17 we're dealing with them as quickly as we possibly  
18 can.

19 MR. CALLEBS: Could you walk  
20 briefly just through an example, just if somebody  
21 needed eyeglasses? So the case manager would  
22 submit that through the state plan services,  
23 right? Or no?

24 MR. GRESHAM: No.

25 MS. SMITH: If they're under 21.

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1 MR. CALLEBS: If they're under 21,  
2 EPSDT?

3 MS. SMITH: Well, it's covered  
4 under vision.

5 MR. CALLEBS: Just covered under  
6 vision. But if they're over 21 --

7 MS. CLARK: It goes through the  
8 waiver.

9 MR. CALLEBS: It is submitted  
10 through the waiver. Okay.

11 MS. CLARK: But we use those fee  
12 schedules --

13 MR. CALLEBS: From the state plan.

14 MS. CLARK: -- from the state  
15 plan, right.

16 MR. CALLEBS: Okay. That's  
17 probably wise then.

18 MS. CLARK: If we allow 50 dollars  
19 here, we wouldn't allow 500 here.

20 MR. CALLEBS: Sure.

21 MS. SMITH: And we've had a lot of  
22 examples where there are frames being submitted  
23 that were over \$500.

24 MR. CALLEBS: I understand that.

25 MR. HARVEY: Nice glasses.

1 MS. SMITH: Nicer than what I  
2 have.

3 MR. CALLEBS: That was probably a  
4 bad example on my part.

5 MS. CLARK: But that's something  
6 we are facing that we're seeing.

7 MR. CALLEBS: Sure. Sure.

8 MR. GRESHAM: There are a lot of  
9 LOIs going out about incontinent supplies, and we  
10 are discussing that with DXC for full replacement  
11 of incontinent supplies. So there's no DME.

12 MS. ELSTUN: It's billed under  
13 traditional waiver. Incontinent supplies like  
14 pads or Depends. They do that, too.

15 MR. GRESHAM: If they have home  
16 health with video, we can get it there. But  
17 otherwise, it's paid under waiver.

18 So we're working on reducing those  
19 LOIs. For some reason Carewise started sending  
20 out LOIs instead of their other practice of  
21 approving A and B services but denying C services.  
22 They would send out an LOI instead of doing a  
23 modification and sending out the appeal rights.  
24 We're back to doing it that way.

25 So we're working with them pretty

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1 much daily to get these issues taken care of.

2 MR. CALLEBS: Is there an  
3 estimated timeframe to clear the backlog?

4 MS. TOWLES: They're working seven  
5 days a week. While we were enjoying our July 4th  
6 holiday, they had a crew working. So they are  
7 literally working nonstop.

8 MR. CALLEBS: Wow!

9 MS. TOWLES: Yes.

10 MR. CALLEBS: Is there some  
11 estimation of how many are left or some  
12 anticipated time that they will be clear --

13 MS. TOWLES: Every day we have an  
14 inventory that's shared amongst everyone so we  
15 know what that inventory is. Like Earl was  
16 saying, there's been some challenges that we're  
17 facing and, unfortunately, we don't know when  
18 that comes up. So we've got to work through  
19 those.

20 MS. BROTHERS: What does your  
21 inventory look like right now? I mean, what's  
22 the backlog look like?

23 MS. TOWLES: I'm sorry, I didn't  
24 know this was a topic of the agenda. So i don't  
25 have exact numbers. So POCs was roughly, which

1 are plan of cares, roughly around 1500. And  
2 level of cares, 600, 700.

3 MR. CHRISTMAN: Sherri, did you  
4 have some other -- you had vision and dental?

5 MS. BROTHERS: Yes, I had some  
6 questions about that. The dental and vision, so  
7 we've had some calls about that being affected,  
8 some of the people on the 1915 waivers even.  
9 When they went in, on the provider, with the new  
10 ruling.

11 So I had some questions that I  
12 wanted to present to the MAC. And that's two  
13 pages of questions. That new ruling that went  
14 into effect with the 1115. And I would just like  
15 to have these questions submitted. And I'm not  
16 going to read all these questions, but I would  
17 like to have them submitted at the MAC meeting.

18 Because it did affect people that  
19 fall under the disability that may not qualify for  
20 a waiver.

21 MR. GRESHAM: We're not able to  
22 submit anything to the MAC if that's what you're  
23 asking us to do.

24 MS. BROTHERS: You don't have to  
25 do that, no.

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1 MS. GRESHAM: The TAC has to do  
2 that. Not us.

3 MS. BROTHERS: Yes, that's what  
4 I'm saying.

5 MR. CHRISTMAN: I will not be able  
6 to attend the MAC meeting.

7 MS. BROTHERS: I will.

8 MR. CHRISTMAN: You will? And I  
9 think we should probably submit that ahead of  
10 time. The woman -- these two motions as well.

11 MS. BROTHERS: Right.

12 MR. CHRISTMAN: You'll take care  
13 of that?

14 MS. BROTHERS: Yeah.

15 MR. CHRISTMAN: Okay. And there's  
16 a person to send it to. I don't recall her name.

17 Do you know who that is?

18 MR. GRESHAM: Are you talking  
19 about Charlotte Lutz?

20 MR. CHRISTMAN: Charlotte, yeah.  
21 Yes.

22 MR. STEVENSON: Could you email that  
23 to us?

24 MS. GRESHAM: And if you have  
25 incidents specific of 1915(c) waiver, we need to

1 see those, too.

2 MS. BROTHERS: Well, it happened  
3 last week, some of the incidences. They went in  
4 to, you know, do their services for dental or  
5 vision, and it showed that they didn't have  
6 benefits either.

7 MS. GRESHAM: We need to know the  
8 examples so we can check on it and make sure that  
9 that's the case.

10 MR. CHRISTMAN: Probably won't be  
11 the only person bringing up dental and vision,  
12 but it's good that we will do it.

13 MS. BROTHERS: Have you all not  
14 had any calls on that?

15 MR. GRESHAM: Not for waiver, no.  
16 Not for 1915(c) waiver.

17 MR. SHANNON: Are these folks  
18 given a 1915(c) waiver now, or are they having  
19 them do them while they're there?

20 MS. BROTHERS: They're actually --  
21 there was providers who actually went in to get  
22 services and they were -- when they pulled up,  
23 they could not get access.

24 MS. CLARK: But they were not  
25 Michelle P or SCL?

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1                   MR. CHRISTMAN: Thank you for  
2 taking care of that. Anybody else plan on going  
3 to the MAC meeting? Johnny?

4                   MR. CALLEBS: I'm going. Can I  
5 ask one more question?

6                   MR. CHRISTMAN: Sure.

7                   MR. CALLEBS: Since we're talking  
8 a little bit about eligibility or services, there  
9 still are a fair amount of instances in which  
10 people who are in either SCL or Michelle P being  
11 randomly reassigned over to the other insurance.  
12 They're going from Optimum to Global or Global to  
13 Optimum, whichever one it is. I always forget.

14                   And so then they're not -- they're  
15 losing their waiver services or waiver because  
16 they're assigned randomly into another -- is it  
17 the Global or the Optimum that's below --

18                   MS. SMITH: It's Global. But what  
19 happens in that -- the way that happens is,  
20 because for waiver -- and I think we've talked  
21 about it before. Remember, we said they have to  
22 have three things to be eligible for waiver.  
23 They have to have a waiver of level of care, they  
24 have to have eligibility, and they have to have  
25 patient liability.

1                   They will show up in Global if  
2   patient liability or that waiver segment is  
3   missing.

4                   MS. PRATHER: Can you say that  
5   again, please?

6                   MS. SMITH: So to get waiver  
7   services, they have to be Medicaid eligible, they  
8   have to have a waiver of level of care, and they  
9   have to have a patient liability segment.

10                  If they are missing their waiver  
11   level of care or their patient liability segment,  
12   they will show up in Global.

13                  Now, we do -- there is a period of  
14   time because of -- you know, you have so long to  
15   submit a re-cert or -- you know, we don't want  
16   people just flipping to managed care or becoming  
17   ineligible because they're in that window, that  
18   grace period.

19                  So, usually, they will stay for --  
20   they'll stay Medicaid eligible for 60 days. But  
21   if their patient liability has ended, then you'll  
22   see them in Global versus eligible for waiver in  
23   like Optimum. But they won't go to a managed care  
24   until it's been after 60 days.

25                  MR. HARVEY: Is there a reason

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1     that that happens, or is there an edit that we  
2     could put in the system to prevent it from  
3     happening?

4                   MS. SMITH: Well, the main reason  
5     that it happens is either there's been something  
6     at their Medicaid re-cert, they waive for  
7     additional information, so something hasn't been  
8     provided, or there's been an issue with their  
9     level of care. It's submitted late or there's  
10    been some kind of system issue. Maybe there's an  
11    issue with a provider number or something.

12                  MR. HARVEY: It sounds like we're  
13    having -- a person could be waiting on submitting  
14    something to the local DCPS office or something  
15    to clear up, an eligibility issue, but while  
16    that's occurring, we create another problem or  
17    another obstacle for them because now they're  
18    just automatically rolled over into the wrong  
19    plan.

20                  MS. SMITH: Well, they're still  
21    Medicaid eligible, and that plan is -- they  
22    really have the same benefits. They're not going  
23    to have their waiver because they don't have a  
24    patient liability on file. They can't access  
25    waiver services, but they are still Medicaid

1 eligible at that point.

2                   The plan historically does omit  
3 something, where you were in Optimum and you had  
4 this many visits of this or you had these  
5 limitations. Now, it is you're -- if you're in  
6 the fee-for-service population, you're in the  
7 fee-for-service population. They have the same  
8 limitations, with the exceptions of the Medicare.

9                   If they're -- what used to be QMB,  
10 or those plans, where if they're KCHIP, those  
11 limitations. But otherwise, it doesn't mean --  
12 like SCL used to always be in Optimum. If you're  
13 in HCB, you used to be in this one. That doesn't  
14 really exist anymore. If they have Medicaid  
15 eligibility, they have Medicaid eligibility.

16                  MS. PRATHER: Can you give me  
17 another example besides the -- maybe the LOC was  
18 submitted late? What was another example?

19                  MS. SMITH: The other thing can  
20 be that primary provider determination. Because  
21 as of today, until August 1st, when the patient  
22 liability changes, you could not have the primary  
23 provider information go over to -- through the  
24 interface to HBE for eligibility until the plan  
25 of care was approved.

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1                   Well, now, because there's not a  
2   primary provider, that information goes over and  
3   can be considered from the moment they meet level  
4   of care. So you don't have those delays of  
5   waiting for the plan of care meeting to occur,  
6   waiting for plan of care to be approved. So that  
7   all can happen on the front end. As soon as they  
8   meet level of care, that can be taken into  
9   consideration for the patient liability to be  
10  considered.

11                  I know it's clear as mud, because  
12  this process is just that way. It just really is.

13                  MS. PRATHER: I was going to say,  
14  I'm sorry, can you repeat that please.

15                  MS. SMITH: It just is a  
16  complicated process. It really is.

17                  MR. CALLEBS: To kind of boil it  
18  down a bit, what you're saying is, there are some  
19  triggers that would cause a person to go from  
20  Global into Optimum -- did I say that right?

21                  MS. SMITH: Uh-huh.

22                  MR. CALLEBS: -- and be out of  
23  waiver status but still Medicaid eligible?

24                  MS. SMITH: Correct.

25                  MR. CALLEBS: There's not a system

1 glitch that's randomly assigning people to this?

2 MS. SMITH: No. No, there's not.

3 MR. CALLEBS: Because that's the  
4 perception, that all of a sudden, you're going  
5 along, find services, re-cert isn't due any time  
6 soon, and then all of a sudden, everything stops  
7 paying, your transportation services are not in  
8 the system anymore, and then they've been  
9 assigned over to an MCO. That's the perception.  
10 Now, whether it's true or not --

11 MS. SMITH: I do know that does  
12 still happen some. So I'm not going to say  
13 100 percent of the time, absolutely, that it  
14 doesn't. And we -- any time we get those  
15 examples, we investigate that.

16 But there is a very methodical  
17 process and very system-heavy -- you know, it's  
18 not dependent on a person. It's looking at --  
19 it's looking for those specific elements in the  
20 system to put them under MCO or to have them in  
21 fee-for-service.

22 MR. CALLEBS: Okay.

23 MR. CHRISTMAN: Any other  
24 questions or comments from anyone in the room?  
25 Then our next meeting is --

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1 MS. CLARK: September 5th. And we  
2 will need the agenda items two weeks in advance.

3 MR. CHRISTMAN: Okay. Then we're  
4 adjourned.

5 (Whereupon, said meeting was  
6 concluded at approximately 11:36 a.m.)

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1     STATE OF KENTUCKY         )  
  ) SS:  
2     COUNTY OF JEFFERSON)

3                 I, Laura L. Wagner, Registered  
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